



LEGALLY SPEAKING
Risk management in obstetrics and gynecology

CASE STUDY: WHEN *NOT* TO ATTEMPT VBAC

By Andrew I. Kaplan, Esq..

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THE FACTS:

The patient, 27 years old and in her 40th week of pregnancy, was admitted to the defendant hospital's Labor and Delivery Floor at approximately 4:15 pm on November 1st, after presenting to her prenatal clinic, where she was diagnosed with oligohydramnios. She had last given birth in 1997, in the Dominican Republic, via cesarean because of a breech presentation. The type of incision performed was undocumented.

At 7 pm on 11/1/2000, the patient was 1 cm dilated and 25% effaced. At 9:10 pm, she was 3 cm dilated, 70% effaced, and the fetus was at -1 station. At approximately 9:30 pm, induction with oxytocin was started. By 1 am, the patient's contractions were described as progressing from mild to moderate; by 1:10 am, they were occurring every 4 to 5 minutes. At 1:30 a.m. the fetal heart rate was in the 150s with adequate variability, and contractions were occurring every 3 to 4 minutes. The patient's cervix was 4 cm dilated and 80% effaced.

At 1:35 am the oxytocin was discontinued and epidural anesthesia administered. Twenty minutes later, the oxytocin was resumed at 4 mIU. At 3:30 am the patient was contracting every 2 to 5 minutes, with occasional decelerations, and the oxytocin was being administered at 7 mIU. By 5 am, the patient's cervix was 5 cm dilated and 100% effaced, and a deceleration to 70 bpm occurred, at which time the fellow, Dr. P, turned the patient on her left side and administered oxygen. At that time, the oxytocin infusion was at 6 mIU. At 5:40 am the nurse-midwife reported that contractions were difficult to pick up on the monitor. The patient's cervix was now 9 cm dilated and the fetus was at 0 station. The nurse-midwife's notation indicated that the physicians still anticipated a spontaneous vaginal delivery.

At 6:15 am, two decelerations to 90 bpm were documented, lasting 40 seconds. At 6:23 am, two additional decelerations to 60 bpm were documented, and the patient was contracting every 3 minutes. At 6:40 am, there was another documented deceleration to 80 bpm for 10 seconds, and at 6:50 am, the epidural was turned off and the patient was encouraged to push. The FHR baseline was 145 bpm, with adequate variability. At 6:55 am, an additional deceleration to 50 bpm for 20 seconds was documented.

At approximately 7:10 am, the nurse-midwife asked Dr. P to evaluate the patient because they were having "difficulties" with the internal monitor. Dr. P noted that the FHR was in the 50 to 60 bpm range and then attempted to replace the internal clip. After multiple "failed" attempts, Dr. P ordered placement of an external monitor. At 7:18 am, after placement of the external monitor, the FHR was noted to be in the 110 to 120 bpm range, with decelerations down to 50 to 60. At 7:20 am, the maternal pulse was 127 bpm, the FHR was 60 to 70 bpm, and uterine contractions were untraceable. At 7:25 am, the maternal pulse was 121 bpm, FHR was between 120 and 130, and the patient was advised that if the FHR decreased again, she would be taken for cesarean delivery. At 7:27 am, the maternal pulse was 127 bpm and the FHR was 120 to 130 bpm, with positive accelerations to 140, but uterine contractions were untraceable.

At 7:40 am, Dr. P was uncertain about whether the monitor was tracing the maternal pulse or the FHR and called the attending, Dr. G, for evaluation. An internal electrode revealed the FHR at 55 bpm, and a stat C/S was called. The C/S was performed at 7:49 am and revealed a uterine rupture and complete placental abruption. The infant was delivered from the peritoneum, resuscitated by neonatology, and immediately transferred to the neonatal intensive care unit for further management. The initial arterial blood gas revealed a pH of 6.87. The infant experienced neonatal seizures and suffered profound developmental, cognitive, and neurologic disabilities.

THE ALLEGATIONS:

The patient asserted that C/S should have been performed earlier and that a trial of labor was contraindicated, given her previous C/S for breech presentation, oligohydramnios, and the lack of information on the location of the prior uterine incision. She further alleged that the physicians were unaware of fetal distress and a significant deceleration in the FHR and mistakenly thought the mother's heart rate was that of the fetus. As a result, the plaintiffs alleged, the physicians failed to appreciate uterine rupture in a timely fashion so as to prevent significant fetal distress, and failed to have the attending obstetrician present throughout the course of this trial of labor.

DISCOVERY:

The fellow, Dr. P, had no explanation for his failure to react to an absent contraction pattern on the tracings after 6:50 am and to the mother's tachycardia. He explained that he was "falsely reassured" that the external monitor was tracing the FHR as opposed to the mother's. Significantly, Dr. P admitted he was

unfamiliar with the meaning or import of a series of "question marks" on the monitoring strips from 7:10 am on.

Our expert in maternal-fetal medicine opined that the case was indefensible. She felt the patient was not a good candidate for VBAC, given her prior cesarean delivery with no information on whether the incision was vertical or transverse. Because that C/S was a breech presentation, she felt that it was likely that a vertical incision had been performed, thus increasing the risk of rupture in a subsequent trial of labor. This expert felt that the mother's uterus ruptured at approximately 7:10 am, when an immediate C/S should have been undertaken, but instead, the fellow and the nurse-midwife improperly focused their attention on whether the fetal monitor was functional.

The expert also noted that dilatation had arrested at 9 cm between 5:40 and 7:40 am, yet oxytocin administration continued, even when the tocodynamometer did not indicate maternal contractions. She felt Dr. P's failure to acknowledge, or even understand, the significance of the "question marks" on the tracings after 7:10 am was egregious. She felt that the infant's initial pH would support the patient's theory that he had been anoxic since approximately 7:10 am, and she pointed out that if more than 17 minutes elapses between uterine rupture and delivery, the risk of profound neurological sequelae significantly increases.

Finally, we had the infant evaluated by a pediatric neurologist, who indicated the child had no purposeful gross motor movements and demonstrated evidence of profound neurologic impairment; severe psychomotor, cognitive, and developmental delay; and spastic quadriplegia. As a result, the pediatric neurologist opined that the infant had a significantly limited life expectancy in the area of 3 to 5 years.

OUTCOME:

As you might imagine, the case settled shortly after Dr. P's deposition. Given the significant exposure in this case (the Appellate Division in the First Department in New York had sustained similar cases in excess of \$28 million) and the inability to find any expert testimony in support of the care, we pursued the opportunity to work out a reasonable settlement, rather than allow a jury to price the infant's damages. Paradoxically, the infant's limited life expectancy decreased the value of the settlement. In cases such as this in which a "structured settlement" is created, one of the significant factors in drafting the annuity and determining the reasonable value of settlement is the anticipated expense for the child's medical and educational needs as he or she ages. Although the case had verdict exposure in the \$12 to \$15 million range, the matter was ultimately resolved for less than \$5 million.

ANALYSIS:

In cases like this one, there are no reasonable explanations for the care rendered and the decisions made, so defense through verdict is impossible. When that happens, the focus turns to diminution of damages—not to deprive the family of appropriate compensation, but to ensure that once the case settles, despite its indefensibility, it results in appropriate remuneration as opposed to a windfall.

Here, there seemed to be a lack of communication and coordination among the physicians and nurse-midwives who handled the patient's care. An outsider reviewing the chart in hindsight—whether it be an attorney or a physician—would almost immediately appreciate the significance of the undocumented prior uterine incision, the patient's oligohydramnios and need for delivery, the added risks of induction of labor and the failure to progress despite increasing dosages of oxytocin during the trial of labor. The physicians involved, however, reacted to their immediate concerns, such as the function of the internal monitor. Had they looked at the big picture, they would almost certainly have realized the increasing risks inherent in attempting VBAC with this patient's presenting risks and subsequent labor anomalies and likely would have, and should have, undertaken earlier C/S.

If nothing else, this case speaks to the benefit and the imperative of maintaining continuity in a patient's course of care. That is particularly important during an attempted trial of labor after prior C/S, when the intrinsic risks are so high.

Andrew I. Kaplan is a Partner at Aaronson Rappaport Feinstein & Deutsch, LLP. Mr. Kaplan graduated from Brooklyn Law School in 1993 and has specialized in medical malpractice defense and health-care litigation since entering private practice.